Delegated practice: 5 ‘rights’ of delegation

Resource

Estimate: 15 mins

Professor Lynn Robinson is the Director of Research and Development at the Centre for Innovation in Professional Learning (CIPL), The University of Queensland, where her interests are in large-scale professional workforce capacity development, particularly using online networks. Before joining CIPL in 2010, she had a long career in the health care sector encompassing general practice, hospital administration, health system reform and health systems research. She has had a lifelong interest in education and has taught many thousands of health professionals on topics related to clinical leadership, teamwork, innovation and quality and safety.

Multimedia resource
In addition to the lecture transcript below, this lecture is available as a multimedia presentation (audio over PowerPoint slides).
# Delegated practice: 5 ‘rights’ of delegation

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### Slide 2

**Overview**

- Standards for task/activity delegation
  - The 5 rights
  - Checklist

**Transcript**

We’re going to have a look now at the individual delegation process. We need to talk about the actual process of delegation of accountability for tasks. What is best practice here?

In such a brief timeframe, we can only do this formulaically. I have chosen two very practical short form tools to help us. We are going to use the 5 ‘rights’ of delegation, which I think is a very good summary.

Finally, we will review the checklist or decision tree which is in common use for delegated practice here and in other states of Australia.
### Task (accountability) delegation

#### 4 or 5 ‘rights’ of delegation (teamwork?)

1. The right task
2. Right circumstances
3. The right person
4. The right communication
5. The right feedback

As the saying goes, depending on which university you go to, you might consider there are either four or five rights of delegation.

Or as I like to think about it, of teamwork or good teamwork.

Here they are. We will look at each in turn.

The right task
- ...in the right circumstances
- ...to the right **person**
- ...in the right way **communicated**
- ...and getting the right **feedback**.
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**The right task**

part of your regular practice

BUT

not exclusively within your scope of practice alone

Firstly, the right task. So, what parts of the team care can be carried out by assistants? This is basically the question. What tasks can be usefully moved within a team or can be established in a team care situation?

For the accountability for part of the care to be moved or shared between the registered health practitioner and an assistant, it needs to be a formal part of the registered health professional's scope of practice. What do we mean by that?

For example, a physiotherapist cannot expect an allied health assistant to discuss with a patient their medication, because this is not normally part of the role of a physiotherapist to begin with. So it is both unreasonable and potentially dangerous for an allied health assistant, to undertake that role, because the supervisor would not normally have that role themselves.

Another example might be if the team includes say, a medical practitioner working with a physician assistant or medical assistant, and that medical practitioner is not normally competent or...
doesn't normally undertake, for example a particular kind of care.

For instance, Parkinson’s disease might not be something which is the normal day-to-day practice of a general practitioner, then it would be both unreasonable and unsafe for someone working with that general practitioner as an assistant, to undertake care for patients with Parkinson's disease.

As a clinical supervisor you cannot supervise the work of others, or the role of others, if you are not yourself normally undertaking that type of work, and are competent and allowed to do that by policy and regulation.

It can’t be something that’s precluded by law or policy from the delegated practice model.

An example of that would be, for example, certain kinds of medication delivery can only be undertaken by a nurse. A nurse cannot then reasonably supervise an assistant in undertaking the medication action, if, under legislative or regulatory control, that action can only be undertaken by a

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<td>doesn't normally undertake, for example a particular kind of care. For instance, Parkinson’s disease might not be something which is the normal day-to-day practice of a general practitioner, then it would be both unreasonable and unsafe for someone working with that general practitioner as an assistant, to undertake care for patients with Parkinson's disease. As a clinical supervisor you cannot supervise the work of others, or the role of others, if you are not yourself normally undertaking that type of work, and are competent and allowed to do that by policy and regulation. It can’t be something that’s precluded by law or policy from the delegated practice model. An example of that would be, for example, certain kinds of medication delivery can only be undertaken by a nurse. A nurse cannot then reasonably supervise an assistant in undertaking the medication action, if, under legislative or regulatory control, that action can only be undertaken by a</td>
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registered nurse.

So the right task is something that you would normally do, but something that you’re not exclusively responsible for doing, and that you actually have the ability to supervise another appropriately skilled person to assist you with.

Let’s look at the right circumstances then. Well, the first right circumstance is that you’ve actually got your structural delegation model in place – the legal policy, job description etc., things that we were talking about earlier are actually in place. The model is very much dependent on them, so individuals can’t in fact operate successfully in a supervisory or assistant relationship, unless the structural process is in place.

But what about other circumstances that impact the decision about whether this is something that can be undertaken by an assistant? Workload, for example, in circumstances where perhaps a rehabilitation assistant might have multiple clinical supervisors, and multiple reporting lines as we alluded to earlier, it’s important to be aware that because somebody is theoretically
capable of doing it, doesn't mean they actually have the ability to be accountable for carrying out that part of the care plan. It's important that the circumstances are right for them to take that responsibility.

There may be additional factors, either with the patient, or perhaps with geography, that would make the transfer of accountability not suitable in some circumstances. So while an assistant may be very comfortable and very capable of embarking on a care plan with a patient in a circumstance where they, say, had the ability to call in somebody to observe if they get into a difficulty. Perhaps that same assistant may not be able to undertake that care plan if they were remotely supervised, say. Or some patients may be more simple than others to provide the same type of care to.

So the complexity of the situation should be taken into account. All situations are different, and that's part of the locally negotiated clinical supervisory relationship that can take into account those variations. And there needs to be an appropriate support available.
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<td>Delegating based on a system of support being in place is not appropriate if the circumstances change and the support is no longer available.</td>
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<td>Consider, is this the right person? This seems fairly straightforward: any team member who is qualified and competent. But we need to tease that out a little bit further. Qualification generally means with the appropriate piece of paper, so this is really reflecting an outcome of a training program. So to be a good clinical supervisor, you need to be familiar with what training has been provided to the people who work with you in the team. But qualifications are more than a piece of paper, they’re actually an understanding of what specific training was included in the qualification of that person. Now if you’re working with people that you’ve trained yourself, then you should be in a position to understand the meaning of that qualification, but also, fortunately in a position to actually have some view of the competence of that</td>
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The right person

- a team member who is
  - qualified
  - competent
  AND

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individual, because as we all know, competence and qualifications don’t always synch exactly together either. And certainly with experience, people, hopefully, get more competent over time with the appropriate clinical supervision in place.

We need to acknowledge that not all assistants are at the same stage of development, not all have had the same training program. And it’s important for every member of the team to have a good understanding of the qualifications and competencies of other members of the team. And particularly if you’re a clinical supervisor, you have a personal responsibility for understanding this about your assistants.
Now we get down to communication. This is a very important part of it. The right communication is where the assistant understands and accepts the goals and outcomes of the care process, the exact and explicit nature of the tasks and processes that you’re delegating. This is helped greatly by the existence of care plans, particularly, for example, in rehabilitation, the explicit care plans that the team is working with.

It’s important to understand the timeframes in which these are to be achieved, and if you have any other expectations as a supervisor, these also need to be made explicit.

Now, a lot of assistants are working in teams, and a lot of these processes become protocol or care plan driven, and that’s wonderful if you’ve got that situation. But it doesn’t let you off the responsibility of actually going over those communications in detail in each and every instance. There may be variations in the patient, there’ll be variations in the circumstances, you may be working with a different assistant.

So a checklist of actually running

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<td>1. Understand AND accept</td>
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<td>1. goals/outcomes</td>
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<td>2. tasks/processes</td>
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<td>3. timeframe</td>
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<td>4. other expectations</td>
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<td>2. 2 way = negotiation</td>
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<td>3. Clear, concise, unambiguous</td>
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<td>through this stuff, having a feedback loop, having your team members actively listen and reflect back what they understand, and having everybody on the same page, is a key ingredient in the right communication.</td>
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<td>And, of course, the communication needs to be two-way, and this comes back again to a full understanding of delegated practice. The person who is taking responsibility needs to ensure that there is an understanding, but also that there’s an acceptance of accountability for that part of the care plan on the part of the assistant.</td>
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<td>It can be quite legitimate for an assistant to actually be comfortable to say, ‘I’m not comfortable to actually undertake that part of the care process. I don’t feel equipped.’ Or ‘I’m not sure that this patient is the right patient for me, I don’t have enough experience.’</td>
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<td>To establish that two-way communication so that assistants, and other members of the team feel free to express their real views of the nature of the delegation process, is really important to patient safety.</td>
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<td>The right feedback</td>
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|              | - Courteous and respectful  
|              | - Timely (booked or variance?)  
|              | - Specific  
|              | - PD opportunity  
|              | - 2 way  

And, of course, the basic principles of good communication always apply - make it clear, be concise, always avoid ambiguity. And we'll be doing some of these activities later where we'll have a closer look at communication.

Finally, the right feedback is very important. Like any relationship, the maintenance of that relationship and the constant, sort of, touching base with each other, and ensuring that while you started on the same page, you continue to be on the same page, is absolutely crucial.

It should go without saying that you should always be courteous and respectful. Teamwork is based on mutual regard for each others’ contributions and common courtesy should apply, preferably in a timely fashion, particularly if things aren’t going to plan, it’s very important that the feedback happens as soon as possible after the variance.

And it should also be important for the assistant to be able to get hold of the supervisor at any time, because they
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<td>may be in a position to work out that things are not going to plan far sooner than the supervisor.</td>
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<td>But while ad hoc feedback continues to be important, it’s equally important to have a disciplined approach to providing feedback.</td>
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<td>One of the things that came out of the Western Australian evaluation of allied health assistants in rural practice, was that the observational parts of the feedback of carrying out of the care plan, in other words, where the therapist came and observed the assistant at work, was valued very highly by both, but also was one of the things that didn’t happen as often as had been agreed.</td>
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<td>So booking and making commitments to timely feedback, is a very important part of the quality assurance process. Feedback should be specific, explicit, positive and constructive.</td>
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<td>And again, feedback can be two-way. Perhaps what went wrong is that the communication at the establishment of the care plan in the first place, wasn’t very effectively done. So it’s important</td>
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In teams to try to establish from the very beginning, the acceptability of feedback being in two directions as a normal way of doing business and as part of good teamwork.

This flowchart is a good summary of considerations which operate when delegating care activities.

It should represent a shared view amongst the whole team at your place about how delegation should or should not take place. Perhaps you should put it on the tea room wall. A copy of this has flowchart is in your kits.
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<td>Summary</td>
<td>So just to summarise. Most of what we have covered is almost ‘common sense’ but it is important that every member of the team shares this particular view of the delegation process. If errors of judgement or process happen at any point in the delegation decision tree – the potential for problems is very great. But if you use these two simple mental tools – the ‘5 rights of delegation’ and the delegation flowchart or decision tree, you should be able to keep yourselves and your patients pretty safe.</td>
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1. The right task
2. (Right circumstances)
3. The right person
4. The right communication
5. The right feedback
6. DELEGATION FLOWCHART
References

5. Western Australia Country Health Service. Allied Health Assistant Program: Delegation, monitoring and evaluation of Allied Health Assistants. Government of Western Australia; 2009.
Learning Goals

Have you met these Learning Goals?

- Understand and apply the five rights of delegation
The 5 ‘rights’ of delegation: 5 scenarios

Learning Goals

- Understand and apply the five rights of delegation

Reflection

If your team is working progressively through the materials in this workshop over a period of weeks, take a moment to quickly refresh your memory of what you have previously covered in this workshop before continuing on with this new topic.

Instructions

Work through the following scenarios one at a time. Depending upon available time your group may choose to do all or only some of the scenarios.

Work individually as you read through a scenario and rate each of the ‘5 Rights’ on the scale provided. Then, share your responses in a group discussion.
1.0 Scenario #1: Patient Care Assistant and Registered Nurse

A patient care assistant (PCA) arrives at the nursing home for a morning shift. As she assists the residents with their breakfast, the registered nurse (RN) gives her the medication cup for the resident she is feeding.

‘Can you give Frank his meds? I have to change Joan’s gastrostomy tube before her GP comes to see her.’

The PCA gives the patient his tablets after feeding him his pureed porridge. Frank has trouble swallowing the pills and starts coughing. The PCA gets alarmed at Frank’s coughing and calls the RN back.

‘You’re supposed to crush them first and mix them with water,’ he tells her, ‘Frank has had a stroke. He can’t swallow tablets.’

On a scale of 1 – 5 (where 1 is extremely well considered and 5 is not considered at all) rate how well each of the five rights of delegation below were considered.

**Question 1.1**
Right task
1  2  3  4  5

**Question 1.2**
Right circumstances
1  2  3  4  5

**Question 1.3**
Right person
1  2  3  4  5

**Question 1.4**
Right communication
1  2  3  4  5

**Question 1.5**
Right feedback
1  2  3  4  5

**Group discussion questions**

Share your responses to questions 1.1 – 1.5 and describe your reasoning behind your ratings of each of these ‘rights’.
2.0  Scenario #2: Intern and Consultant Anaesthetist

Peter, an intern, is in the first week of his anaesthetics rotation. The patient to be anaesthetised is a 24-year-old female cyclist having an arthroscopy. The consultant anaesthetist takes Peter through a structured assessment of his previous training in airway management, anaesthetic equipment and the use of anaesthetic drugs.

The consultant then induces the patient and supervises Peter while he intubates her. After supervising his intubation technique, the consultant asks Peter to monitor the patient, document the anaesthetic and calculate the incremental anaesthetic drug doses required during the procedure.

The consultant moves a few feet away and picks up a journal and starts reading it, saying to Peter, ‘Okay, Peter, I’ll leave you in charge. Ask me if you are unsure of anything and let me know when the surgeon starts to close, because I’ll do the extubation. Do you feel comfortable about this? Is there anything you don’t understand?…Good…after we’ve finished here, we’ll tackle that bun-loaf in the staff room with a cup of tea and talk about how you went.’

On a scale of 1 – 5 (where 1 is extremely well considered and 5 is not considered at all) rate how well each of the five rights of delegation below were considered.

**Question 2.1**
Right task

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**Question 2.2**
Right circumstances

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**Question 2.3**
Right person

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**Question 2.4**
Right communication

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**Question 2.5**
Right feedback

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Group discussion questions

Share your responses to questions 2.1 – 2.5 and describe your reasoning behind your ratings of each of these ‘rights’.
3.0 Scenario #3: Pharmacy Assistant and Pharmacist

Mrs Faraday has stopped off at a pharmacy on her way to pick up her 12-month-old son from day care. The day care centre had earlier rang her to say that her son has a runny nose and other upper respiratory symptoms and is sneezing over the other children.

Mrs Faraday asks the pharmacist about decongestants for her infant. The pharmacist calls the new pharmacy assistant over saying, ‘I have to process some scripts urgently, can you grab some Dimetapp for Mrs Faraday’s son? She’s in a hurry.’ The pharmacy assistant gets Mrs Faraday the Dimetapp and rings it up on the cash register for her.

Mrs Faraday leaves but returns to the pharmacist later that afternoon because the strength and dosage of the Dimetapp is for children 2 years and older. The pharmacist is very apologetic and corrects the error by supplying the correct formulation. He later takes the pharmacy assistant to task for not checking the formulation. She is quite upset, as this is her first job as a pharmacy assistant and she didn’t know that Dimetapp came in different strengths.

On a scale of 1 – 5 (where 1 is extremely well considered and 5 is not considered at all) rate how well each of the five rights of delegation below were considered.

**Question 3.1**
Right task

1 2 3 4 5

**Question 3.2**
Right circumstances

1 2 3 4 5

**Question 3.3**
Right person

1 2 3 4 5

**Question 3.4**
Right communication

1 2 3 4 5

**Question 3.5**
Right feedback

1 2 3 4 5
**Group discussion questions**

Share your responses to questions 3.1 – 3.5 and describe your reasoning behind your ratings of each of these ‘rights’.
4.0 Scenario #4: Dietary Aide and Dietitian

Mark is a dietary aide. It is his second day working within the dietetic team, at a large regional hospital. His task for the morning is to fill in the dietary cards for the patients on the general medical ward. Although he has been shown the cards and been provided with relevant information, this is his first time doing this task in the ‘real world’.

The lunch plating has already started in the kitchen when he receives a call from one of the dietitians. She seems very flustered and tells him a patient has just been admitted. ‘Fill out the standard menu card for a renal diabetic’, she tells him. As he is about to ask her to give him more details, she cuts him off. ‘I have to go…I’m late for ICU rounds,’ she says and hangs up.

Mark hasn’t filled in a menu card for this type of patient before and there is no one available to ask. He tries to ring the dietitian back but her phone is off.

Later, Mark receives a call from the dietitian because the patient with type 1 diabetes and chronic renal failure has been delivered a standard meal. The dietitian meets with Mark that afternoon to discuss the error and get his input.

On a scale of 1 – 5 (where 1 is extremely well considered and 5 is not considered at all) rate how well each of the five rights of delegation below were considered.

**Question 4.1**
Right task

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**Question 4.2**
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**Question 4.3**
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**Question 4.4**
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**Question 4.5**
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Group discussion questions

Share your responses to questions 4.1 – 4.5 and describe your reasoning behind your ratings of each of these ‘rights’.
5.0 Scenario #5: Allied Health Assistant and Rehabilitation Program Manager

Wendy Ling is an experienced allied health assistant who lives in Shimmering Waters and works in the town’s community health centre. Shimmering Waters is a small country town, about 2 hours drive from Tropicana, the nearest regional centre.

Maya is a physiotherapist who belongs to the rehab unit of the Tropicana Hospital. Maya is responsible for the Tropicana Health Service District and visits Shimmering Waters once a month. She has recently set up a stroke rehabilitation program that can be administered by rehabilitation assistants in her absence.

Maya has a patient who has recently suffered a stroke and is due to be discharged to Shimmering Waters on Monday. Maya rings Wendy and informs her of Mrs Taddeo’s imminent arrival.

‘Mrs Taddeo will be there on Monday. I’m coming out on Tuesday, Wendy, so I will take you through her program then. It’s all documented and sets out what to do. It’s very clear. I’ll need you to take her through it three times a week and I’ll be back in a month to reassess her. We can case conference by phone in the interim and you can ring me anytime if there’s anything you want to discuss. Have you got time to fit her in?’

On a scale of 1 – 5 (where 1 is extremely well considered and 5 is not considered at all) rate how well each of the five rights of delegation below were considered.

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<th>Question 5.2</th>
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Group discussion questions

Share your responses to questions 5.1 – 5.5 and describe your reasoning behind your ratings of each of these ‘rights’.
6.0 Ensuring a shared understanding of the '5 Rights'

The following slide is taken from Professor Lynn Robinson’s presentation ‘Delegated practice: 5 ‘rights’ of delegation’.

**Summary**

1. The right task  
2. (Right circumstances)  
3. The right person  
4. The right communication  
5. The right feedback  
+ DELEGATION FLOWCHART

**Group discussion questions**

1. It is important for healthcare teams to have a shared understanding of each of the ‘5 Rights’. What can your team do to ensure that you will continue to have a shared understanding of each of the '5 Rights' as you go about your everyday clinical practice?
Instructions

In the space provided below write down the agreed actions for how your team will continue to ensure a shared understanding of each of the ‘5 Rights’ in your everyday clinical practice.
Delegated practice: 5 ‘rights’ of delegation

Estimate: 15 minutes

Learning Goals

Have you met these Learning Goals?

- Understand and apply the five rights of delegation

Authority

This training program has been developed by The University of Queensland’s Centre for Innovation in Professional Learning for use by the Department of Health and Hospital and Health Services established under the Hospital and Health Boards Act 2011 (Qld).